TEXAS DEPARTMENT OF CRIMINAL JUSTICE
HEALTH SERVICES DIVISION

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name (print): **<~PATIENT_NAME~>** Offender #: **<~MRN~>**
Facility: **<~FACILITY~>** Date of Birth: **<~PATIENT_DOB~>**

By signing this Authorization Form, I understand that I am giving my authorization to TDCJ's designated medical records custodians or any other entity that may possess my medical records to use and/or disclose my protected health information (PHI), as described in more detail in the paragraphs below, to the following person(s) or organization(s):

Name of person(s) or organization(s): _____

Street address: _____

City, State, and zip code: _____

Telephone number: _____

Facsimile number: _____

I specifically authorize the use and disclosure of the following PHI:

(Please provide a detailed description of the particular information you are authorizing to be disclosed)

_____

Please state the purpose of the authorization to release PHI below: (example: continuity of patient care, personal reasons, legal review)

_____

The information to be used or disclosed pursuant to this authorization form may include information relating to:

(1) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus ("HIV") infection; (2) treatment for drug or alcohol abuse; or (3) mental or behavioral health or psychiatric care.

Unless earlier revoked, this authorization will expire on the 730th day of the signature date or as otherwise specified below:

The authorization will be voided if I am released from TDCJ custody prior to the expiration date.

I understand the information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or Texas privacy law.

I may inspect and received a copy (Texas law establishes nominal fees for copy charges of medical records) of the information to be used and disclosed pursuant to this Authorization form.

This Authorization is voluntary and I may refuse to sign this Authorization form.

I may revoke this authorization at any time by notifying the medical record unit at my facility of assignment in writing of my intent to revoke this authorization. However, I also understand that such a revocation will not have any effect on any information already used or disclosed by TDCJ before TDCJ received my written notice of revocation.

If I am providing authorization for marketing purposes, I understand that TDCJ may receive remuneration from a properly authorized business associate as a result of using or disclosing my PHI.

I understand that I am not required to sign this Authorization form in exchange for receiving treatment from TDCJ.

Signature of patient or personal representative		Date
Printed Name of Patient		
Printed name of personal representative (if applicable)		

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